**APPENDIX- C**

**SERVICE DESCRIPTIONS (PLEASE NOTE- THE PROPOSED RENEWAL CHANGES ARE INCLUDED IN TRACK). ALL OTHER INFORMATION WILL REMAIN THE SAME.**

**Appendix C-1**

**Summary of Services Covered**

1. **Adult day health services**

**Service Type: Statutory service**

|  |
| --- |
| **Check this box:** |
| **( ) Service is included in the approved waiver. There is no change in service specifications**  **( ) Service is included in approved waiver. The service specifications have been modified.**  **(x) Service is not included in the approved waiver.** |

**Service Title: Adult day health services**

**Service Definition:**

Adult day health services are designed to encourage adults enrolled in the EPD waiver to live in the community by offering non-residential medical supports and supervised, therapeutic activities in an integrated community setting, to foster opportunities for community inclusion, and to deter more costly facility-based care.

Adult day health services include the following services: medical and nursing consultation services including health counseling to improve/maintain the health, safety and psycho-social needs of persons enrolled in the waiver; individual and group therapeutic activities, including social, recreational and educational activities provided by licensed therapists such as an occupational or physical therapist, and speech language pathologist; social service supports provided by a social service professional including consultations to determine the person’s need for services, offering guidance through counseling and teaching on matters related to the person’s health, safety, and general welfare; direct care supports services to provide direct supports such as personal care assistance, offering guidance in performing self-care and activities of daily living, instruction on accident prevention and the use of special aides; and medication administration services provided by a Registered Nurse (RN) including administration of medication and/or assistance in self administration of medication as appropriate. Persons enrolled in the waiver will also have the option of receiving nutrition and meal services consisting of nutritional education, training, and counseling to persons enrolled and their families, and provision of meals and snacks while in attendance at the day setting. All services will be offered under the person’s individualized service plan and be tailored in accordance with their unique needs and choices.

Additionally, in accordance with 42 CFR 441.301, all adult day health service providers will meet the “setting requirements”, as verified by the DHCF EPD Waiver Provider Readiness Review process.

These include the following:

1. The setting is integrated in, and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive

integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

1. The setting is selected by the person from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.
2. Ensures a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.
3. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
4. Facilitates individual choice regarding services and supports, and who provides them.

In addition to the Provider Readiness Reviews, the District will utilize an additional assessment process to ensure that the persons seeking to receive services from the adult day health providers under the EPD waiver are living in settings that comply with the provisions of the HCBS federal regulation. DHCF will use the nurses that conduct face-to-face, conflict-free, standardized assessments of applicants seeking long term care services and supports described under Appendix B (evaluation/revaluation of care) to determine the person’s level of need for services under the waiver. The nurses will also capture additional information to verify and ensure that the person who receives adult day services is living in an environment that comports with the HCBS standards reflected above (441.301 (c)(4)(i-v)) and the additional standards that pertain to provider-owned or controlled residential settings as set forth under 441.301 (c)(4)(vi). Administration of the assessment process during the face-to-face assessments conducted in a person’s residence ensures that the persons accessing adult day services under the EPD waiver live in settings that promote community living.

These include the following:

* 1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the person receiving services, and the person has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;
  2. Each person has privacy in their sleeping or living unit:
     1. Units have entrance doors lockable by the person, with only appropriate staff having keys to doors;
     2. Persons sharing units have a choice of roommates in that setting; and
     3. Persons have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement;
  3. Persons have the freedom and support to control their own schedules and activities, and have access to food at any time;
  4. Persons are able to have visitors of their choosing at any time;
  5. The setting is physically accessible to the person; and
  6. Any modification of the additional conditions specified in §441.301(c)(4)(vi)(a) through (d), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
     1. Identify a specific and individualized assessed need;
     2. Document the positive interventions and supports used prior to any modifications to the person-centered service plan;
     3. Document less intrusive methods of meeting the need that have been tried but did not work;
     4. Include a clear description of the condition that is directly proportionate to the specific assessed need;
     5. Include regular collection and review of data to measure the ongoing effectiveness of the modification;
     6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
     7. Include the informed consent of the person; and
     8. Include an assurance that interventions and supports will cause no harm to the individual.

**Limitations in amount, duration, and scope:**

1) A provider will not be reimbursed for adult day health services if they do not meet the “setting” requirements under 42 CFR 441.301 as verified by the Provider screening and Readiness Review.

2) A provider shall not be reimbursed for adult day health services if the person enrolled in the waiver is concurrently receiving the following services:

1. Day Habilitation or Individualized Day Supports under the 1915 (c) Waiver for Individuals with Intellectual and Developmental Disabilities (ID/DD);
2. Intensive day treatment or day treatment mental health rehabilitative services (MHRS) under the District of Columbia State Plan for Medical Assistance (State Plan);
3. Personal Care Aide services; (State Plan or 1915 (c) waivers);
4. Services funded by the Older Americans Act of 1965, Title IV, Public Law 89-73, 79 Stat. 218, as amended; Public Law 97-115, 95 Stat. 1595; Public Law 98-459, 98 Stat. 1767; Public Law 100-175; Public Law 100-628, 42 U.S.C. 3031-3037b; Public Law 102-375; Public Law 106-501; or
5. 1915 (i) State Plan Option services under the State Plan.

3) Additionally, a provider shall not be reimbursed for adult day health services if the person is receiving intensive day treatment mental health rehabilitation services at the same time, or during a twenty-four (24) period that immediately precedes or follows the receipt of adult day health services to ensure that the person is receiving services in the setting most appropriate to his/her clinical needs.

4) Adult day health services shall not be provided for more than five (5) days per week and for more than eight (8) hours per day.

5) Adult day health services may be used in combination or on the same day as PCA services, as long as these services are not billed “concurrently” or during the same time.

**Provider Qualifications:**

**License**:

All individual health practitioners shall be licensed in accordance with the District of Columbia’s Department of Health’s Health Occupations Revisions Act. “Health Occupations Revision General Amendment Act of 2009” as incorporated into Title 3, Chapter 12 of the District of Columbia Official Code.

**Certificate:**

Have a valid certificate of Need (CON) as determined by the District of Columbia State Health Planning and Development Agency.

**Other Standards:**

1. Have a Medicaid Provider Agreement with DHCF to be enrolled as an adult day health providerunder the EPD Waiver;
2. Meet DHCF’s Provider Readiness Review process which will ensure that the following are in place:
3. A service delivery plan to render delivery of adult day health services;
4. A staffing and personnel training plan in accordance with any of DHCF’s requirements;
5. Policies and procedures in accordance with any requirements set by DHCF; and

(d) Data elements for ensuring compliance with the home and community-based setting requirements in accordance with 42 CFR 441.301; and

(3) EPD Waiver Providers of Adult Day Health shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.

### Verification of Provider Qualifications

### Entity Responsible for Verification:

Entity responsible for verification –DHCF’s Long Term Care Administration will conduct an initial provider screening and readiness review to ensure EPD Waiver programmatic requirements. The provider screening and readiness review will include an on-site visit to ensure that the elements of the Provider Readiness Review are in place. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

**Frequency of verification:**

DHCF’s Long Term Care Administration will monitor programmatic requirements at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years).DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enro1ling applicants) to verify provider readiness.

**Specify whether the service may be provided by***(check each that applies)***:**

 **Legally Responsible Person**

 **Relative (check relative)**

**Legal Guardian**

1. **Homemaker**

**Service Type: Statutory service**

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| --- |
| **Check this box:** |
| **( ) Service is included in the approved waiver. There is no change in service specifications**  **(x) Service is included in approved waiver. The service specifications have been modified.**  **( ) Service is not included in the approved waiver.** |

**Service Title: Homemaker**

**Service Definition** *(Scope):*

Services consisting of general household activities food preparation and storage, and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent and/or unable to manage the home and/or care for him or herself and/or others in the home. These services do not need to be supervised by a RN.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

1. Homemaker services may be provided only in cases where neither the individual nor anyone else in the household is able to provide the service or pay for the provision of the service.
2. An individual or family member other than the person’s spouse, parent of a minor child, any other legally responsible relative, or court-appointed guardian may provide homemaker services. Legally responsible relatives do not include parents of an adult child, so parents of an adult child enrolled in the waiver are not precluded from providing Homemaker services.

**Service Delivery Method** *(check each that applies)*:

**Participant-directed as specified in Appendix E  Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

 **Legally Responsible Person**

 **Relative**

**Legal Guardian**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Homemaker**



Individual

**Provider Category: Change Individual to Agency or Business**

### Provider Type:

##### Home care agencies, Licensed provider of housekeeping services

**Provider Qualifications License** *(specify):*

Be a home care agency licensed pursuant to the requirements for home care agencies as set forth in the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code, §§ 44-501 *et seq*. (2005 Repl. & 2012 Supp.)), and implementing rules; or

Have a general business license issued by the Department of Consumer and Regulatory Affairs to perform housekeeping services in the District of Columbia.

**Certificate** (specify) –

**Other Standard** (specify):A person providing homemaker services shall meet one of the following-

(a) If employed by a home care agency, be certified as a Home Health Aide in accordance

with Chapter 93 of Title 17 of the District of Columbia Municipal Regulations; or

(b) If employed by a business licensed to perform housekeeping services, obtain a minimum of eight (8) hours of training annually in the following areas:

* 1. Residents Rights;
  2. Communicating Effectively with persons enrolled in the waiver;
  3. Preventing Abuse, Neglect and Exploitation;
  4. Controlling the Spread of Disease and Infection;
  5. Changing linens and bed bug prevention;
  6. Food preparation, handling, and storage;
  7. Safe handling of cleaning chemicals (use of gloves, goggles/masks);
  8. Handling hazardous waste;
  9. Blood-borne pathogens and bodily fluids; and
  10. Instructions on the following-
      1. Dusting
      2. Maintenance of floors (mopping/vacuuming)
      3. Laundry and safe use of detergents
      4. Trash handling
      5. Cleaning Walls and ceiling
      6. Kitchen/Bathroom cleaning/maintenance

**Provider Standards:**

1) If a home care agency enrolled to provide homemaker services, also be enrolled as a Medicare home health agency qualified to offer skilled services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 CFR § 484; or

2) Be enrolled as an EPD Waiver Provider of Homemaker services; and

3) Have a current Medicaid provider agreement on file with the DHCF before providing any waiver services;

##### 4) Providers must have bylaws or similar documents regulating conduct consistent with waiver and regulatory requirements; and

5) Home Care Agency providers of homemaker services shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.

**Individual Homemaker standards:**

1) Be at least 18 years of age;

2) Be able to successfully communicate with the person receiving EPD

Waiver services;

3) Each person providing homemaker services shall either be certified as a Home Health Aide in accordance with Chapter 93 of Title 17 of the District of Columbia Municipal Regulations; or complete the annual training requirements for homemakers as specified in this section. ,;

;

4) Maintain an updated CPR certificate; and

5) Pass a criminal background check.

### Verification of Provider Qualifications

### Entity Responsible for Verification:

DHCF’s Long Term Care Administration will conduct an initial provider screening and provider readiness review to ensure EPD Waiver programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

**Frequency of Verification:**

DHCF’s Long Term Care Administration will monitor programmatic requirements at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enro1ling applicants) to verify provider readiness.

**3) Personal Emergency Response System (PERS)**

**Service Type: Other**

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| --- |
| **Check this box:** |
| **(x) Service is included in the approved waiver. There is no change in service specifications**  **( ) Service is included in approved waiver. The service specifications have been modified.**  **( ) Service is not included in the approved waiver.** |

**Service Title:**

Personal Emergency Response System (PERS)

**Service Definition** *(Scope):*

PERS is an electronic device that enables certain persons at high risk of institutionalization to secure help in emergency situations by activating a system connected to the person’s phone that is programmed to signal a response when a portable “help” button is activated.

Each system is comprised of three basic elements: (a) a small radio transistor (portable help button) carried by the user; (b) a console or receiving base connected to a user’s telephone; and (c) a response center or responder to monitor the calls.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

1. No PERS will be provided to persons enrolled in the waiver who live with an individual who assumes responsibility for the safety of the recipient.
2. No PERS will be provided for persons who are unable to understand and demonstrate proper use of the system.
3. No PERS will be provided to persons who live with an individual who assumes responsibility for providing care (to the person enrolled in the waiver) and the person is not left alone for significant periods of time.
4. PERS response center support must be provided on a 24-hours per day, 7-days per week basis;
5. Emergency equipment repair service must be available to the person on a 24-hours per day, 7-days per week basis; and
6. The PERS provider must allow the person to designate respondent(s) who will respond to emergency calls. Respondents may be relatives, friends, neighbors or medical personnel.

**Service Delivery Method** *(check each that applies)*:

 **Participant-directed as specified in Appendix E  Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

 **Legally Responsible Person**

 **Relative**

**Legal Guardian**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Personal Emergency Response System (PERS)**



Agency

**Provider Category: Change to Business**

**Provider Type Business**

**Provider Qualifications License** *(specify):* Business in good standing

**Certificate** *(specify):*

NA

**Other Standard** *(specify):*

Each business or provider of Medicaid reimbursable PERS services shall have a current license, certification, or registration with the District of Columbia as appropriate for the electronic system being purchased. Each business, or provider shall also demonstrate knowledge of applicable standards of manufacture, design, and installation. In order to be eligible for Medicaid reimbursement, the 24-hour-7 day a week emergency response center shall be monitored by trained operators capable of determining if an emergency exists and notifying emergency services and the person’s respondent. Each provider of PERS shall develop and maintain an incident reporting process that requires notification to DHCF within twenty four (24) hours of a reportable emergency response.

Have a Medicaid Provider Agreement with DHCF to be enrolled as an adult day health provider under the EPD Waiver

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHCF’s Long Term Care Administration will conduct an initial provider screening and readiness review to ensureEPD Waiver programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

**Frequency of Verification:**

DHCF’s Long Term Care Administration will monitor programmatic requirements at least annually.

# DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enro1ling applicants) to verify provider readiness.Respite

**Service Type: Statutory service**

|  |
| --- |
| **Check this box:** |
| **(x) Service is included in the approved waiver. There is no change in service specifications**  **( ) Service is included in approved waiver. The service specifications have been modified.**  **( ) Service is not included in the approved waiver.** |

**Service Title: Respite**

**Service Definition** *(Scope):*

Services provided to persons enrolled in the waiver who are unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those individuals who normally provide care for the person.

Federal financial participation is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence, including a Medicaid enrolled group home, or other community care residential facility approved by the State that is not a private residence. Respite services may cover the range of activities associated with the Personal Care Aide role or the Homemaker role. These include, but are not limited to the following activities:

##### Basic personal care such as bathing, grooming, and assistance with toileting or bedpan use;

1. Assistance with prescribed, self-administered medication;
2. Meal preparation in accordance with dietary guidelines and other cultural/religious dietary restrictions, and assistance with eating;
3. Household tasks related to keeping the recipient’s living areas in a condition that promotes the recipient’s health, comfort, and safety; and
4. Accompanying the recipient to medically related appointments.

### Specify applicable (if any) limits on the amount, frequency, or duration of this service:

1. Respite services shall not include services that require the skills of a licensed professional, including catheter insertion, procedures requiring sterile techniques, and medication administration.
2. Respite services shall not include tasks usually performed by chore workers, including cleaning of areas not occupied by the recipient, cleaning laundry for family members of the recipient, and shopping for items not used by the recipient.
3. Respite services shall not be provided to persons who have no primary caregiver who is responsible for the provision of the person’s care on an ongoing basis. Respite services are only available to beneficiaries who have a live-in, unpaid caregiver (non-PCA). Respite services are available for beneficiaries' unpaid caregivers (non-PCAs) for a maximum of 480 hours per waiver certification for hours that are not otherwise staffed by a personal care aide. DHCF will make exceptions to provide respite services to beneficiaries whose unpaid primary caregivers are not living with them.
4. Respite services are limited to a maximum of four hundred and eighty (480) hours per year. Requirements for respite services in excess of the established limits must be approved by DHCF prior to the provision of the services.
5. An individual or family member other than a person’s spouse, parent of a minor child, any other legally responsible relative, or court-appointed guardian may provide respite services. Legally responsible relatives do not include parents of an adult child, so parents of an adult child enrolled in the waiver are not precluded from providing respite.
6. If respite care is provided in a facility other than a person’s residence, the facility must meet all the “setting” requirements under 42 CFR 441.301 and be enrolled as a Medicaid provider of respite services.

**Service Delivery Method** *(check each that applies)*:

 **Participant-directed as specified in Appendix E  Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

 **Legally Responsible Person**

 **Relative**

**Legal Guardian**

**C-1/C-3: Provider Specifications for Service**

**Service Type:** Statutory Service

**Service Name: Respite**



Agency

**Provider Category:**

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License** *(specify):*

Be a home care agency licensed pursuant to the requirements for home care agencies as set forth in the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code, §§ 44-501 *et seq*. (2005 Repl. & 2012 Supp.)), and implementing rules

**Certificate** *(specify):*

Staff providing respite care services must be certified as home health aides or a personal care aides in accordance with Chapter B-39 of Title 22-B of the D.C.M.R.

##### Staff providing respite care must complete twelve hours [12] of continuing education annually.

**Other Standard** *(specify):*

1. Be enrolled as a Medicare home health agency qualified to offer skilled services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 CFR § 484; and

2) Have a current Medicaid provider agreement on file with DHCF before providing any waiver services.

3) The home care agency must develop and implement an initial intake protocol that assesses the person’s respite needs and the appropriate level of care required to meet the person’s needs. This initial intake assessment must be conducted by a Registered Nurse (RN) who is: (a) duly licensed to practice in the District of Columbia, and is (b) employed by the home care agency. A copy of the initial intake assessment must be on file with the home care agency.

4) The initial assessment conducted by the R.N. must: (a) establish a written emergency notification plan for each person receiving respite care services; and (b) document that the emergency notification requirement must be kept on file with the home care agency for a period of not less than ten (10) years.

##### 5) An individual providing respite services may not leave the home or place of residence of the person during the period of time which respite care is being provided, unless the home care agency that is responsible for providing the services replaces such caregiver prior to the caregiver removing himself from the person’s home or primary place of residence; and

6) Home Care Agency providers of respite services shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.

**Verification of Provider Qualifications Entity Responsible for Verification:**

DHCF’s Long Term Care Administration will conduct an initial provider screening and readiness review to ensure EPD Waiver programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

**Frequency of Verification:**

DHCF’s Long Term Care Administration will monitor programmatic requirements at least annually. DHCF’s Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years).DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enro1ling applicants) to verify provider readiness.

**5) Chore Aide**

Service Type: Other Services

|  |
| --- |
| **Check this box:** |
| **( ) Service is included in the approved waiver. There is no change in service specifications**  **(X) Service is included in approved waiver. The service specifications have been modified.**  **( ) Service is not included in the approved waiver.** |

**Service Title: Chore Aide**

**Service Definition** *(Scope):*

Chore Aide services consist of heavy house-hold chores to maintain the home in a clean, sanitary, and safe environment, including washing floors, windows, and walls, tacking down loose rugs, and tiles, and moving heavy items of furniture in order to provide for the person’s and other individual provider’s safe entry and exit. Ideally, the chore aide prepares the home environment so as to be safe and clean that make the way for more routine and ongoing routine homemaker services. This includes heavy house cleaning of the household so as to initially ensure the homemaker can conduct light household cleaning on a more routine basis.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

A unit is a one hour spent performing allowable task(s). Maximum amount of service permitted under the waiver is 32 units (quantity of four, eight-hour days) per person for the five year waiver period. Service shall be limited to thirty two (32) units per person. Reimbursement for chore aide services may not be claimed by providers who provide services in residences where another party is otherwise responsible for the provision of the service, such as group home providers.

Chore aide services are provided only in cases where neither the person receiving services nor

anyone else in the household, or the person’s landlord, or third party payor is able or responsible for providing the service under a lease or other agreement.

Chore aide task must be performed in accordance with an Individualized Services Plan [ISP]. In

the case of rental property and residential facility, the responsibility of the landlord and/or

homeowner, pursuant to the lease agreement, [or other applicable laws and regulations] must be

examined (by the case manager) prior to the authorization of chore aide services. It is the

responsibility of the case manager to ensure that the requisite documents have been reviewed

prior to ordering chore aide services under the ISP. DHCF may grant or deny exceptions to

the number of units allowed for a person’s use of Chore Aide services.

An individual or family member other than the person’s spouse, parent of a minor child, any other legally responsible relative, or court-appointed guardian may provide chore aide services. Legally responsible relatives do not include parents of an adult child, so parents of an adult child enrolled in the waiver are not precluded from providing chore aide services.

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Chore Aide Provider Category:**

Provider Type:

Home Care Agency; or Licensed provider of housekeeping services

**Provider Qualifications License** *(specify):*

Be a home care agency licensed pursuant to the requirements for home care agencies as set forth in the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code, §§ 44-501 *et seq*. (2005 Repl. & 2012 Supp.)), and implementing rules; or

Have a general business license issued by the Department of Consumer and Regulatory Affairs to perform housekeeping services in the District of Columbia

**Certificate** *(specify):*

**Other Standard** *(specify):*

1. If enrolled as a home care agency, also be enrolled as a Medicare home health agency qualified to offer skilled services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 CFR § 484; or

2) Be enrolled as an EPD waiver Provider of Chore Aide Services; and

##### 3) Have a current Medicaid provider agreement on file with DHCF before providing any waiver services;

##### 4) Providers must have bylaws or similar documents regulating conduct and internal affairs via established Policies and Procedures

##### 5) Individual Chore Aide worker standards are as follows:

(a) If employed by a home care agency, be certified as a Home Health Aide in accordance with Chapter 93 of Title 17 of the District of Columbia Municipal Regulations; or

(b) If employed by a business licensed to perform housekeeping services, obtain a minimum of eight (8) hours of training annually in the following areas:

* + - 1. Residents Rights;
      2. Communicating Effectively with persons enrolled in the waiver;
      3. Preventing Abuse, Neglect and Exploitation;
      4. Controlling the Spread of Disease and Infection;
      5. Changing linens and bed bug prevention;
      6. Safe handling of cleaning chemicals (use of gloves, goggles/masks);
      7. Handling hazardous waste;
      8. Blood-borne pathogens and bodily fluids; and
      9. Instructions on the following-
         1. Maintenance of floors (mopping/vacuuming)
         2. Trash handling
         3. Cleaning Walls and ceiling
         4. Kitchen/Bathroom cleaning/maintenance
  + Chore aides must be 18 years of age and pass a criminal background check
  + Chore services must include a pre- and post-cleaning inspection of the home by the Home Care Agency, licensed business providing housekeeping services, and documentation indicating that the home environment has been placed in a state of readiness for ongoing, routine housekeeping (i.e homemaker, and/or personal care aide services). Chore services will not be reimbursed by DHCF unless the Long Term Care Administration is provided with pre-and-post-cleaning documentation; and

6) Home Care Agency providers of chore aide services shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.

**Verification of Provider**

**Qualifications**

DHCF’s Long Term Care Administration will conduct an initial provider screening and readiness review to ensure EPD Waiver programmatic requirements . Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

**Entity Responsible for Verification:**

DHCF’s Long Term Care Administration will monitor programmatic requirements at least annually. DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enro1ling applicants) to verify provider readiness.

**6) Personal Care Aide**

### Service Type: Statutory service

|  |
| --- |
| **Check this box:** |
| **( ) Service is included in the approved waiver. There is no change in service specifications**  **(x) Service is included in approved waiver. The service specifications have been modified.**  **( ) Service is not included in the approved waiver.** |

### Service: Personal Care Aide

**Please Note-** The PCA SPA will be updated in the Summer/Fall with more detailed language about safety monitoring. The Waiver language specifies that the scope of duties of a PCA in the Waiver are consistent with the State Plan., so safety monitoring under the Waiver can only go into effect once the PCA SPA is amended to reflect “Safety monitoring”.

**Service Definition** *(Scope):*

Tasks include cueing, assistance with activities of daily living, safety monitoring, and instrumental activities of daily living. Services involving assistance with one or more activities of daily living that is rendered by a qualified personal care aide under the supervision of a registered nurse. The scope, service authorization, and nature of these services do not differ from personal care services furnished under the State plan. The allowable tasks and provider qualifications/certifications specified in the State plan apply.

### Specify applicable (if any) limits on the amount, frequency, or duration of this service:

1. Limitations do not differ from any established under the Medicaid State Plan with the exception of the following-

(a) To be eligible for PCA services, PCA services must be included in the person’s person-centered PCP, and a person must be in receipt of a service authorization for EPD Waiver services as established by the receipt of a score of nine (9) or higher on the standardized assessment tool which equates to a nursing home level of care (or higher) including extensive assistance or total dependence with two or more ADLs.

b) PCA services under the waiver are limited to a total of sixteen (16) hours per day for seven days a week; and

c) PCA services related to meal preparation shall be in accordance with the person’s dietary guidelines, including low sodium intake guidelines, or other restrictions, and also take into account any cultural/religious dietary preferences in accordance with the PCP.

##### 2) Payment shall be provided at an hourly rate established by DHCF. The unit of service is fifteen (15) minutes. Payment will be the reimbursed units determined by the service authorization and billed in accordance with the person-centered individual service plan.

3) An individual or family member other than the person’s spouse, a parent of a minor child, any other legally responsible relative, or court-appointed guardian may provide PCA services. Legally responsible relatives do not include parents of an adult child, so parents of an adult child enrolled in the waiver are not precluded from providing PCA services.

4) Other limitations include the following:

1. PCA services shall not include services that require the skills of a licensed professional, such as catheter insertion, procedures requiring the use of sterile techniques, and medication administration.

##### Shall not include tasks usually performed by chore workers or homemakers, such as cleaning of areas not occupied by the recipient, laundry for family members, and shopping for items not used by the person, or money management.

1. Shall not be provided in a hospital, nursing facility, intermediate care facility for individuals with intellectual disability or institution for mental disease, or any other living arrangement which includes PCA services as a reimbursed service. However, persons residing in assisted living may receive services upon prior authorization by DHCF or its agent.
2. When a recipient is receiving PCA services and homemaker services from two different staff persons who are employees of the same agency, all supervisory registered nurse (RN) visits shall be coordinated so that supervisory in-home RN visits are made in accordance with waiver standards and the supervisory in-home RN visits are made by the same supervising RN at the same time.
3. When a person is receiving PCA and any adult day health services (waiver or State Plan) on the same day, the combination of both PCA and adult day services shall not exceed a total of sixteen (16) hours per day, and services may be used in combination or on the same day as PCA services, as long as these services are not billed “concurrently” or during the same time .

**Service Delivery Method** *(check each that applies)*:

 **Participant-directed as specified in Appendix E  Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

 **Legally Responsible Person**

 **Relative**

**Legal Guardian**

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Personal Care Aide\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



Agency

**Provider Category: Agency**

### Provider Type:

Home Care Agency

**Provider Qualifications License** *(specify):*

Be a home care agency licensed pursuant to the requirements for home care agencies as set forth in the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code, §§ 44-501 *et seq*. (2005 Repl. & 2012 Supp.)), and implementing rules; and

**Certificate** *(specify):* N/A

**Other Standard** *(specify):*

1) Be enrolled as a Medicare home health agency qualified to offer skilled services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 CFR § 484;

##### 2) Have a current Medicaid provider agreement on file with DHCF as an enrolled EPD Waiver provider before providing any waiver services;

3) All Personal Care Aides shall have the same qualification and standards as established under the Medicaid State Plan including certification under Chapter 93 of Title 17 of the DCMR; and

4) Home Care Agency providers of personal care aide services shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.

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**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHCF’s Long Term Care Administration will conduct an initial provider screening and readiness review to ensure EPD Waiver programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

**Frequency of Verification:**

DHCF’s Long Term Care Administration will monitor programmatic requirements at least annually. DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enro1ling applicants) to verify provider readiness.

**Service Delivery Method** *(check each that applies)*:

 **Participant-directed as specified in Appendix E  Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

 **Legally Responsible Person**

 **Relative**

**Legal Guardian**

**7) Environmental Accessibility Adaptation Services**

### Service Type: Other Services

### Service Title:

Environment Accessibility and Adaptation Services

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| --- |
| **Check this box:** |
| **( ) Service is included in the approved waiver. There is no change in service specifications**  **(x) Service is included in approved waiver. The service specifications have been modified.**  **( ) Service is not included in the approved waiver.** |

**Service Definition** *(Scope):*

Those physical adaptations to the private residence of the person or the person’s family, required by the person's person-centered individual service plan, that are necessary to ensure the health, welfare and safety of the person seeking EAA services or that enable the person to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars/hand-rails, widening of doorways, installation of lift systems, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the person enrolled in the waiver .

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The maximum allowable cost per person seeking EAA services is $10,000. This rate is inclusive of a five hundred dollar ($500) reimbursement rate for the costs associated with the home inspection or evaluation. All service(s) required are subject to approval or denial by the State Agency prior to the provision of such service(s). This is a one-time service limited to $10,000 per person over the duration of the waiver.

Both certified home-owners, and renters are eligible for EAA services. EAA services will only be approved or reimbursed for a certified home owner who can demonstrate that they are ineligible for the Handicap Accessibility Improvement Program (HAIP) administered by the DC Department of Housing and Community Development. The case manager shall assist all eligible and certified home owners to apply for the HAIP program. If a home owner is denied participation in the program, the person seeking EAA services must provide a copy of the denial letter to the case manager. Renters will be exempt from proving ineligibility for HAIP.

In the case of rental property and/or leased property, no EAA services will be approved or reimbursed unless the following conditions are met: 1) the current rental and/or lease agreement, or residential agreement (and all other relevant documents) are thoroughly examined (by the case manager) to determine whether EAA services are prohibited or allowed with conditions, and (2) a signed release was obtained from the management of the property authorizing the EAA home modifications to be made. Case Managers will only contact landlords with the permission of the person receiving services.

**Service Delivery Method** *(check each that applies)*:

 **Participant-directed as specified in Appendix E  Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

 **Legally Responsible Person**

 **Relative**

**Legal Guardian**

**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

**Service Name: Environment Accessibility and Adaptation Services Provider Category: Individual**

**Provider Type**:

Certified Third Party Construction Inspector, Licensed Contractor, or Licensed Building Contractor.

**Provide Qualifications**

**License** *(specify):*

All Contractors shall be licensed by the Department of Consumer and Regulatory Affairs;

**Certificate** *(specify):*

Certified Third Party Construction Inspector shall be certified under the District of Columbia Department of Consumer and Regulatory Affairs, Third Party Inspector Program

**Other Standard** *(specify):*

1) All persons must be able to demonstrate to the EPD waiver participant the ability to successfully communicate with them. Individuals and businesses providing services and supports shall have all the necessary licenses required by federal, state and local laws and regulations, IF APPLICABLE.

2) Contractors must bee enrolled as a EPD Waiver provider.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHCF’s Long Term Care Administration will conduct an initial provider screening and readiness review to ensure programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

**Frequency of Verification:**

DHCF’s Long Term Care Administration will monitor programmatic requirements at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enro1ling applicants) to verify provider readiness.

**8) Assisted Living**

Service Type: Other Service

Service Title:

Assisted Living

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| --- |
| **Check this box:** |
| **( ) Service is included in the approved waiver. There is no change in service specifications**  **(x) Service is included in approved waiver. The service specifications have been modified.**  **( ) Service is not included in the approved waiver.** |

**Service Definition** *(Scope):*

Assisted living services are personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to persons enrolled in the waiver who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). Services that are provided by third parties must be coordinated with the assisted living provider.

All activities associated with providing or coordinating personalized assistance through activities of daily living, recreational activities, 24-hour supervision, and provision or coordination of health services and instrumental activities of daily living.

As specified in DHCF’s transition plan (see Amendment, Attachment #2, HCBS Transition Plan), DHCF’s Long Term Care Administration (LTCA) is adopting a new EPD Provider Readiness Review Checklist which will be used to process renewals of assisted living providers’ status as EPD waiver providers and to verify compliance with the following requirements under 42 CFR 441.301:

* 1. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
  2. The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
  3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
  4. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
  5. Facilitates individual choice regarding services and supports, and who provides them.
  6. In a provider-owned or controlled residential setting, in addition to the qualities specified above, the following additional conditions must be met:
     1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
     2. Each individual has privacy in their sleeping or living unit:
     3. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
     4. Individuals sharing units have a choice of roommates in that setting.
     5. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
     6. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
     7. Individuals are able to have visitors of their choosing at any time.
     8. The setting is physically accessible to the individual.

(Xii)Any modification of the additional conditions specified in §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(1)Identify a specific and individualized assessed need.

(2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(3) Document less intrusive methods of meeting the need that have been tried but did not work.

(4) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.

(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(7) Include the informed consent of the individual.

(8) Include an assurance that interventions and supports will cause no harm to the individual.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Assisted Living service does not include housing or meals. Payment will not be made for 24 hour skilled care or supervision; room and board; costs of facility maintenance; and upkeep and improvement. Beneficiaries cannot concurrently bill assisted living with PCA without receiving a prior authorization from DHCF.

A provider will not be reimbursed for assisted living services if they do not meet the “setting” requirements under 42 CFR 441.301 as verified by the Provider screening and Readiness Review process.

**Service Delivery Method** *(check each that applies)*:

 **Participant-directed as specified in Appendix E  Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

 **Legally Responsible Person**

 **Relative**

**Legal Guardian**

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

**Service Name: Assisted Living Provider Category: Agency**

**Provider Type:** Assisted Living Facility

**Provider Qualifications**

**License** *(specify):*

Facility must be licensed by the District of Columbia Health Regulation Administration

Staff RN and/or LPN must maintain current State license

**Certificate** *(specify):*

Copies of current license and certification of staff, Personal Care Aides. Medication Technician, Homemaker

**Other Standard** *(specify):*

Have a Medicaid Provider Agreement and be enrolled as an EPD Waiver Provider;

Be in compliance with the Assisted Living Resident Regulatory Act of 2000 (DC St. §§ 44-101.01 *et seq*.), and Chapter 34 of Title -22 B of the DCMR

### Assisted Living service Providers shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.

### Verification of Provider Qualifications

**Entity Responsible for Verification:**

DHCF’s Long Term Care Administration will conduct an initial provider screening and readiness review to ensure programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services. District of Columbia, Department of Health, Health Regulation, and Licensing Administration is also responsible for verification of license.

**Frequency of Verification:**

DHCF’s Long Term Care Administration will monitor programmatic requirements at least annually.

# DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enro1ling applicants) to verify provider readiness.

DOH verifies upon review and approval of initial license and every year.

**9) Occupational Therapy Services**

**Service Type- Other**

|  |
| --- |
| **Check this box:** |
| **( ) Service is included in the approved waiver. There is no change in service specifications**  **( ) Service is included in approved waiver. The service specifications have been modified.**  **( x) Service is not included in the approved waiver.** |

**Service Title- Occupational Therapy Service**

**Service Definition***(Scope):*

Occupational Therapy services are designed to maximize independence, prevent further disability, and maintain health, and the person’s functionality. These services should be provided in accordance with the person-centered PCP. All Occupational Therapy services should be monitored to determine which services are most appropriate to enhance the person's well-being and to meet the therapeutic goals. This is not an extended state plan service. This service may be used in addition to or in place of the state plan service if indicated as needed by the physician. This service differs from the state plan service by provider qualifications and locations where service may be delivered. The occupational therapist, under the HCBS waiver, is not restricted to those employed by home care agencies. This service may be delivered by any licensed practitioner and is delivered in the person's home or day service setting.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

If the person is between the ages of 18 and 21, the case manager will ensure that EPSDT services are fully utilized and the HCBS waiver service is not replacing or duplicating services. The EPD waiver unit also serves as a quality control when authorizing service plans to monitor the appropriate use of EPSDT and other State Plan services as appropriate. Services are limited to 4 hours per day and 100 hours per year. Requests for additional hours may be approved when accompanied by a physician's order or if the request passes a clinical review by staff designated by the State Medicaid Director to provide oversight on clinical services.

**Service Delivery Method** *(check each that applies)*:

 **Participant-directed as specified in Appendix E  Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

 **Legally Responsible Person**

 **Relative (check relative)**

**Legal Guardian**

|  |
| --- |
| [**Return to Summary of Services**](https://wms-mmdl.cdsvdc.com/WMS/faces/protected/35/apdxC1_1.jsp) |

**Service Type: Other Service**

**Service Name: Occupational Therapy**

**Provider Category: Individual**



**Provider Type: Occupational**



**Provider Qualifications**

**License***(specify):*

An Occupational Therapist licensed to practice occupational therapy in accordance with the requirements of Chapter 63 of Title 17 of the D.C.M.R; or

Be a home care agency licensed pursuant to the requirements for home care agencies as set forth in the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code, §§ 44-501 *et seq*. (2005 Repl. & 2012 Supp.)), and implementing rules.

### Other Standards-

### Be enrolled as an EPD Waiver Provider

### Home Care Agency Providers enrolled to provide EPD Waiver OT services shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.

### Verification of Provider Qualifications

**Entity Responsible for Verification:**

DHCF’s Long Term Care Administration will conduct an initial provider screening and readiness review to ensure programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services. District of Columbia, Department of Health, Health Regulation, and Licensing Administration is also responsible for verification of license.

**Frequency of Verification:**

DHCF’s Long Term Care Administration will monitor programmatic requirements at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enro1ling applicants) to verify provider readiness.

DOH verifies upon review and approval of initial license and every year.

**10) Physical Therapy**

**Service Type- Other**

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| --- |
| **Check this box:** |
| **( ) Service is included in the approved waiver. There is no change in service specifications**  **( ) Service is included in approved waiver. The service specifications have been modified.**  **( x ) Service is not included in the approved waiver.** |

**Service Title- Physical Therapy Service**

**Service Definition**

Physical Therapy (PT) services are designed to maximize independence, prevent further disability, and maintain health, and the person’s functionality.

They are also designed to treat the identified physical dysfunction or the degree to which pain associated with movement can be reduced. They should be provided in accordance with the person’s individual service plan. All PT services will be monitored to determine which services are most appropriate to enhance the person’s well-being and meet the therapeutic goals.

This is not an extended state plan service. This service may be used in addition to or in place of the state plan service if indicated as needed by the physician. This service differs from the state plan service by provider qualifications and locations where the service may be delivered. The Physical Therapy professional under the HCBS waiver is not restricted to those employed by home care agencies. This service is delivered by any licensed practitioner and is delivered in the individual's home or day service setting.

**Specify applicable limits on the amount, duration, and scope of services**

If the person is between the ages of 18 and 21, the case manager will ensure that EPSDT services are fully utilized and the HCBS waiver service is not replacing or duplicating services. The EPD waiver unit also serves as quality control when authorizing service plans to monitor the appropriate use of EPSDT and other State Plan services as appropriate. Services are limited to 4 hours per day and 100 hours per calendar year. Requests for additional hours may be approved when accompanied by a physician's order or if the request passes a clinical review by staff designated by State Medicaid Director to provide oversight on clinical services.

**Provider Category: Individual**



**Provider Type:** Physical Therapist or Physical Therapy Assistant working under direct

supervision

**Provider Qualifications**

**License***(specify):*A physical therapist licensed to practice physical therapy in accordance with the requirements of Chapter 67 of Title 17 of the DCMR.

A physical therapy assistant licensed to practice as a physical therapy assistant in accordance with the requirements of Chapter 82 of Title 17 of the D.C.M.R.

**Home Care agency**

License-

Health-Care and Community Residence Facility Act, Hospice and Home-Care Licensure Act of 1983, effective Feb. 24, 1984 (DC Law 5-48; DC Official Code, § 44-501 et seq), and implementing rules.

### Other Standards-

### Be enrolled as an EPD Waiver Provider

### Home Care Agency Providers providing EPD Waiver PT services shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.

### Verification of Provider Qualifications

**Entity Responsible for Verification:**

DHCF’s Long Term Care Administration will conduct an initial provider screening and readiness review to ensure provider qualifications of Home care agency. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services. District of Columbia, Department of Health, Health Regulation, and Licensing Administration is also responsible for verification of license.

**Frequency of Verification:**

DHCF’s Long Term Care Administration will monitor programmatic requirements at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enro1ling applicants) to verify provider readiness.

DOH verifies upon review and approval of initial license and every year.

**11)** **Individual-Directed Goods and Services**

**Service Type**: Other

|  |
| --- |
| **Check this box:** |
| **( ) Service is included in the approved waiver. There is no change in service specifications**  **(x) Service is included in approved waiver. The service specifications have been modified.**  **( ) Service is not included in the approved waiver.** |

**Service Title**:

Individual-Directed Goods and Services

**Service Definition (Scope)**:

Services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the person-centered Individual Service Plan (PCP) (including improving and maintaining the individual’s opportunities for full membership in the community) and meet the following requirements. The item or service would:

• decrease the need for other Medicaid services; and/or

• promote inclusion in the community; and/or

• increase the waiver participant’s safety in the home environment.

Individual-directed goods and services are only available to waiver participants who are enrolled in the Services My Way program, which is the participant-directed services (PDS) program in the District of Columbia. Furthermore, individual-directed goods and services are only available if the individual does not have the funds to purchase the good or service or the good or service is not available through another source. Individual-directed goods and services are purchased from the participant’s PDS budget. Experimental or prohibited treatments are excluded. Individual-directed goods and services must be documented in the participant’s person-centered PCP and approved by the Services My Way Program Coordinator at DHCF.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Waiver participants who elect to enroll in the Services My Way program may purchase individual-directed goods and services that are included in their person-centered PCP, meet the criteria listed above and are within the means of their PDS budget to purchase. Support brokers help participants revise their PDS budgets, as necessary, to account for new, appropriate individual-directed goods and services they would like to purchase and help them manage their PDS budgets.

Upon revising a PDS budget to reflect a new individual-directed good or service, the support broker submits the revised PDS budget to the Services My Way Program Coordinator . The Program Coordinator reviews all requested individual-directed goods and services , and either approves or denies the requested item. Upon approval, the Services My Way Program Coordinator will submit the amended PDS budget to the Vendor Fiscal/Employer Agent (VF/EA) Financial Management Services (FMS)-Support Broker entity, allowing the VF/EA FMS-Support Broker entity to authorize payment of vendor invoices submitted for the approved individual-directed goods and services.

**Service Delivery Method (check each that applies):**

Participant-directed as specified in Appendix E

**Provider Specifications**:

**Service Type**: Other Service

**Service Name**: Individual-Directed Goods and Services

**Provider Category**:

Individual

**Provider Type**:

Individual/vendor as selected by the participant

**Provider Qualifications**

**License (specify):**

Valid business license in good standing, if applicable.

**Certificate (specify):**

N/A

**Other Standard (specify):**

All individuals/vendors providing individual-directed goods and services must be at least eighteen (18) years of age. All individuals/vendors must be able to: (1) demonstrate to the waiver participant that they have the capacity to perform the requested work and the ability to successfully communicate with him/her; and (2) have all necessary professional and/or commercial licenses required by federal, state and local statutes and regulations, if applicable.

Individuals/vendors providing non-medical transportation as an individual-directed service must have: (1) a valid driving license and (2) the minimum amount of liability insurance required by the District of Columbia for the type of vehicle used to provide the transportation. Furthermore, if applicable, individuals/vendors shall enter into a Medicaid provider agreement, as required by CMS, which shall be executed by the VF/EA FMS-Support Broker entity on behalf of DHCF.

**Verification of Provider Qualifications**

**Entity Responsible for Verification**:

VF/EA FMS-Support Broker entity

**Frequency of Verification**:

At time of enrollment and thereafter as necessary.

**12) Participant –Directed Community Support Services**

**Service Type**: Other

|  |
| --- |
| **Check this box:** |
| **( ) Service is included in the approved waiver. There is no change in service specifications**  **(x) Service is included in approved waiver. The service specifications have been modified.**  **( ) Service is not included in the approved waiver.** |

**Service Title**:

Participant-Directed Community Support (PDCS)

**Service Definition (Scope):**

Participant-Directed Community Support (PDCS) is available to waiver participants enrolled in the Services My Way program as described in Appendix E. Services offered under PDCS are detailed in the participant’s person-centered Individual Service Plan (PCP) and PDS budget and are designed to promote independence and ensure the health, welfare, and safety of the participant.

The participant or his/her designated representative, as applicable, is the common law employer of the participant-directed worker (PDW) providing services. These PDWs are recruited, selected, hired, and managed by the participant/representative-employer. As described in Appendix E, supports are available to assist the participant/representative-employer with employer-related responsibilities through the VF/EA FMS-Support Broker entity.

**Allowable Tasks:**

Tasks performed by a PDW include cueing, assistance with activities of daily living, safety monitoring, and instrumental activities of daily living.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The tasks performed under PDCS are similar to those performed by a personal care aide (PCA). However, PDCS is provided pursuant to a person’s PDS budget and uses a different rate methodology as described in Appendix E. Payment will not be made to a PDW who is the participant’s (a) spouse or (b) parent or, if minor participant, legal guardian.

All PDCS services provided by a PDW must be prior authorized in order to participate in the Services My Way program.

1) To be eligible for PDCS, a participant must:

(a) PDCS services must be included in the participant’s person’s person-centered PCP, and the participant must be in receipt of a service authorization for EPD Waiver services as established by the receipt of a score of nine (9) or higher on the standardized assessment tool which equates to a nursing home level of care (or higher) including extensive assistance or total dependence with two or more ADLs.

2) Payment shall be provided in accordance with the participant’s PDS budget and at an hourly wage within the wage range prescribed by DHCF. The hourly wage for a PDW shall be no less than the DC living wage and no more than the hourly wage paid to a PCA. Payment is dictated by the amount, duration, and scope of services determined in accordance with the participant’s service authorization pursuant to the face-to-face assessment conducted by DHCF or its agent.

3) An individual or family member other than the participant’s spouse, a parent of a minor child, any other legally responsible relative, or court-appointed guardian may act as a PDW. Legally responsible relatives may not act as PDWs. Legally responsible relatives do not include parents of an adult child, so parents of an adult child participant are not precluded from providing PDCS services.

4) Other limitations on PDCS include the following:

1. PDCS shall not include services that require the skills of a licensed professional, such as catheter insertion, procedures requiring the use of sterile techniques, and medication administration.

2. PDCS shall not include tasks usually performed by chore workers or homemakers, such as cleaning of areas not occupied by the participant, laundry for family members, shopping for items not used by the participant, or money management.

3. PDCS shall not be provided in a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID) or institution for mental disease, or any other living arrangement which includes PCA services as a reimbursed service.

4. When a person is receiving PDCS and any adult day services (waiver or State Plan) on the same day, the combination of both PDCS and adult day services shall not exceed a total of sixteen (16) hours per day.

**Service Delivery Method (check each that applies):**

Participant-directed as specified in Appendix E

**Specify whether the service may be provided by (check each that applies):**

Relative

**Provider Specifications**:

**Service Type**: Other Service

**Service Name**: Participant-Directed Community Support

**Provider Type:**

Individual, Participant-Directed Worker

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

N/A

**Other Standard (specify):**

Participant-directed workers (PDWs) must meet the following qualifications:

a. Be at least eighteen (18) years of age;

b. Complete and pass a criminal background check pursuant to the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999, as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code §§ 44-551 et seq.);

c. Receive customized training provided by the participant and/or his/her authorized representative;

d. Be able and willing to provide the service-related responsibilities outlined in the participant’s person-centered PCP;

e. Be certified in cardiopulmonary resuscitation (CPR) and First Aid and maintain current certifications; and

f. Not be a participant in the Services My Way program.

**Verification of Provider Qualifications**

**Entity Responsible for Verification**:

The participant or authorized representative if designated as the common law employer of PDWs, and the VF/EA FMS-Support Broker entity determining if PDW has met minimum qualifications.

**Frequency of Verification**:

At time of PDW recruitment prior to hire, and thereafter, once hired, as necessary. The VF/EA FMS-Support Broker entity verifies that PDW qualifications are met during the employment process and executes a Medicaid provider agreement with each PDW on behalf of DHCF.

**13) Case Management**

**Service Type: Statutory**

|  |
| --- |
| **Check this box:** |
| **( ) Service is included in the approved waiver. There is no change in service specifications**  **(x) Service is included in approved waiver. The service specifications have been modified.**  **( ) Service is not included in the approved waiver.** |

**Service Definition** *(Scope):*

The conflict-free case management (CM) service is designed to ensure that the Medicaid beneficiary in need of long-term care services and supports (LTCSS) has opportunities to engage in community life, control personal resources, seek employment and work in competitive and integrated settings while receiving services in the community to the same degree as people who do not receive Medicaid funded services. CM services are provided to individuals who are residing in a community setting or transitioning to a community setting following an institutional stay. Transitional CM services are temporary and are only provided to facilitate a person’s transition back to the community if the person is institutionalized; regular CM services are continuously provided during the person’s enrollment in the waiver when they are residing in the community. Transitional CM services may be provided for a period not to exceed one hundred and twenty (120) days. Transitional CM services include assistance connecting or re-connecting to community resources and services and discharge planning.

The case manager is responsible for assessment, planning, linkage, monitoring, and advocacy relative to the particular needs of the person, where the resources necessary may be external (e.g., housing and education) or internal (e.g., identifying and developing skills). This includes assisting the person to access and maintain all public benefits to which he/she may be entitled. The case manager’s role is to support the person in developing a written comprehensive person-centered individual service plan (PCP) for Medicaid and non-Medicaid services (including community resources) that reflects the person’s strengths, interests, preferences, community and family supports, personal goals, financial resources, and assessed needs. Based on this plan, the case manager assists the person in accessing an individualized mix of services detailed in the PCP in the most integrated community setting appropriate to his/her needs and desires, and provides ongoing monitoring of the person’s use of the services and supports detailed in the PCP. Additionally, the case manager advocates on the person’s behalf within service networks while ensuring the person accesses and stays connected to all public benefits for which he/she is eligible. CMs do not replace family systems and/or other community services, but augment the person’s natural supports.

**I. Requirements for Person Centered Planning (PCP)**

The case manager shall commit to making services fit persons, rather than making persons fit services, and enable a PCP process, directed by the person with long-term services and support needs (or a representative they choose), that meets the following requirements:

(1) Occurs at a time and location that is convenient for the person and any other individuals that person wants included in the planning;

(2) Includes face-to-face discussions with the person whose plan is being developed, other contributors chosen and invited by the person, and representatives of the person’s interdisciplinary team, as possible;

(3) Incorporates feedback of members of the person’s interdisciplinary team and other key individuals if and when they are unable to participate in face to face discussions inclusive of the individual;

(4) Ensures that information shared with the person is aligned to his or her acknowledged cultural preferences and communicated in a manner that ensures the person and/or his or her representative understands the information. Communication must be consistent with the policies/practices of the US Health and Human Services Office on Minority Health Standards National Standards on Culturally and Linguistically Appropriate Services (CLAS) https://www.thinkculturalhealth.hhs.gov/content/clas.asp. If needed, auxiliary aids and services should be provided;

(5) Provides meaningful access to persons and/or their representatives with limited English proficiency (LEP), including low literacy materials and interpreters;

(6) Uses a strengths-based approach to identifying the positive attributes of the person, including an assessment of the person’s strengths, preferences, and needs;

(7) Embraces the personal preferences of the individual to develop goals and to meet the person’s needs;

(8) Explores employment and housing in integrated settings, where planning is consistent with the individual’s goals and preferences, including where the individual resides and who they live with; and

(9) Ensures that persons under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, have the opportunity to address any concerns related to the person-centered Individual Service Planning process.

**II. Development of the Person-Centered Individual Service Plan**

The case manager shall ensure that the person-centered PCP highlights the person’s strengths and that it aligns with the person’s articulated quality of life goals, service and support needs, and preferences. Specifically, the person-centered PCP must:

(1) Document the person’s strengths and positive attributes at the beginning of the plan;

(2) Document the goals of the person and/or representative in his or her own words, which tie to the specific amount, duration, and scope of services that will be provided;

(3) Document the person’s preferences related to end of life planning, as appropriate;

(4) Be in a language and dialect and at the literacy level needed to be understandable for the person and/or his or her representative;

(5) Specify the other contributors chosen and invited by the person to engage in the PCP and in monitoring the implementation of the PCP;

(6) Include consideration of and any resulting goals for employment, education and community participation;

(7) Identify necessary services and supports, to be provided through Medicaid and non-Medicaid services, including supports from the person’s family, friends, faith-based entities, recreation centers, or other available community resources;

(8) Prevent duplicative, unnecessary or inappropriate services by identifying only the necessary services chosen by the person;

(9) Identify the specific persons and/or health care providers and/or other entities providing services and supports;

(10)Develop, in partnership with the person, a risk mitigation plan (along with a back-up emergency plan); the plan must consider the person’s right to assume some level of responsibility for the identified risk and solutions to mitigate them;

(11)Assure the health and safety of the person;

(12)Document the following (if a person’s needs related to health and safety warrants restrictions on the person’s environment):

(a) The explicit and individualized assessed safety need;

(b) Positive interventions used in the past to address the same or similar safety risk;

(c) Explanation of the condition directly related to the specified safety need;

(d) Description of plan modifications addressing the safety risk, and the results of routine collection of data measuring the effectiveness of the modification;

(e) Documentation that the person and/or representative understands and consents to the proposed modification;

(f) Time limit determined to evaluate if safety modification is still necessary or can be terminated; and

(g) Assurance that the modification will not cause harm to the person.

(13)Address components of self-direction if the person has chosen a Services My Way Program;

(14)Assure the person’s needs will be addressed in the case of a District-wide emergency, such as a black-out or District-wide electronic system failure;

(15)Receive final approval and signature of the completed person-centered Individual Service Plan from those who participated in its planning and development, with mandatory signatures of the person and the case manager.

(16)All contributors chosen and invited by the person to participate in the PCP process must receive a copy of the completed PCP (or a component of the plan, as determined by the person).

**III. Implementing and Monitoring the Person-Centered Individual Service Plan (PCP)**

The case manager shall work with the person to implement the person-centered Individual Service Plan. Specifically, the case manager shall:

(1) Assist with initiating services and accessing community supports.

(2) Coordinate care across the various and multiple services and /or providers connected to the PCP, regardless of source of payment.

(3) Monitor the person to ensure that needs and preferences are being met and that the person receives services described in the PCP in type, scope, duration, and frequency. If results of routine monitoring activities necessitate updates to the PCP, this should be done within seven (7) days of said monitoring activity, with approval signatures from those who participated in PCP planning and development, with mandatory signatures of the person and the case manager.

(4) Review and update the PCP at least every twelve months or when the person’s functional needs change, circumstances change, quality of life goals change, or at the person’s request.

(a) The case manager must respond to personal requests for updates within forty-eight (48) hours, with completion of the update within seven (7) days.

(b) The updated PCP must be done via face-to-face discussions with the person whose plan is being developed, other contributors chosen and invited by the person, and representatives of the person’s interdisciplinary team, as possible.

(c) The updated PCP must incorporate feedback of members of the person’s interdisciplinary team and other key individuals if and when they are unable to participate in face to face discussions inclusive of the person.

(d) The updated PCP must include approval signatures from those who participated in PCPplanning and development, with mandatory signatures of the person and the case manager, and be shared with other EPD Waiver providers, with the permission of the beneficiary, to facilitate a beneficiary’s care coordination,

(5) Ensure the person continues to meet the EPD-required Level of Care (LOC)

1. Review the initial assessment at least every twelve months to determine if an individual has had a significant change in health status

2. If the CM’s review reflects a change (i.e., improvement or worsening) in health status, the CM shall note changes, and shall request a LTCSS assessment by DHCF or its designee (via submission of a signed Prescription Order Form from the beneficiary’s physician or APRN)

3. If there is no change in health status, the CM will attest that the individual continues to meet the EPD-required Level of Care. This attestation must be communicated to ESA as a part of the Medicaid recertification process.

(6) Assist in obtaining required documents for the initiation of and on-going maintenance of services (e.g., securing physician orders, etc.), particularly at the time of required renewals and recertification.

1. The application for recertification should be submitted 60 days prior to the Medicaid expiration date.

2. CMs should begin working on the recertification package upon receipt of the recertification package by DHCF, or no later than 90 days prior to the Medicaid expiration date, whichever is earlier.

(7) Ensure quality of care and service provision, including identification and resolution of problems with providers and services identified in the PCP.

(8) Provide supportive counseling to the person and family, as appropriate.

(9) Maintain records to provide supportive documentation of all conflict-free CM services provided. All records must be maintained in a manner consistent with federal and District of Columbia privacy and confidentiality rules.

(10) Ensure that Medicaid renewals and any required re-certifications are complete before the end of a person’s renewal or certification period, including ensuring the person obtains annual level of care redetermination.

(11)Monitors implementation of PCP via monthly (at minimum) check-ins that are documented in DC’s electronic CM system to ensure that persons are receiving services per the plan.

**IV. Conflict Free Requirements**

CMs must be “conflict-free,” and shall not:

(1) Be related by blood or marriage to the person, or to any paid caregiver of the person;

(2) Be financially responsible for the person, or be empowered to make financial or health decisions on the person’s behalf;

(3) Hold financial interest or have a financial relationship, defined under 42 CFR 411.354, in any entity that is paid to provide care for the individual; and

(4) Be employed or under contract to a provider of a person’s other direct program services under the EPD Wavier.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Included in this service unit are the following activities, related to general oversight of the person relative to their person-centered Individual Service Plan:

1. Conducting monthly home visits, at minimum) to check on the person and to ensure services are provided in accordance with the PCP
2. Communicating and coordinating with the person whose plan is being developed, other contributors chosen and invited by the person, and representatives of the person’s interdisciplinary team, as needed and possible;
3. Communicating regularly with service providers as needed (e.g., providers of other EPD waiver services such as Personal Care Aide services and medical professionals such as gerontologists, etc.);
4. Coordinate with other involved case managers or care coordinators (i.e., ADRC transition coordinators or lead agency social workers, etc.);
5. Documenting all case management activities;
6. Conduct functional evaluation and assist the person to obtain level of care re-determination and Medicaid recertification, as needed;
7. Communicating with State agency personnel, as needed; and
8. Any other activities related to the efficient administration of the PCP.

The following limits are applicable to billing-

For transitional case management services provided during a person’s institutional stay, billing for those services may occur only after the person returns to the community setting (not during the person’s institutional stay). Billing shall be contingent upon demonstration of activities that occurred during the person’s institutional stay to facilitate transition to the community such as discharge planning, and assistance in accessing community resources.

The person and/or authorized representatives may elect to receive or not receive any waiver services by signing the “Beneficiary Freedom of Choice Form.”

Note that service providers

* May not receive Medicaid reimbursement for case management services to persons who are not Medicaid beneficiaries ; and
* May not provide medical, financial, or legal services (except for referral to qualified individuals, agencies or program).

**Case Management Agency**

**Provider Qualifications**

License (specify):

Case management agencies are required to be enrolled as a provider in the District of Columbia Medicaid Program as case management agencies in the EPD waiver. Staff providing conflict-free case management services must have current appropriate licensure, and have a Masters and one year of experience with the population, with either a degree in Social work, Psychology, Counseling, Rehabilitation, Nursing, Gerontology, or sociology OR a Bachelors degree and the above current licensure and 2 years of experience with the population OR Registered Nurse [RN] can have an Associate Degree and 3 years of experience

Waiver rules, “Home and Community-Based Waiver Services for Persons who are Elderly and Individuals with Physical Disabilities,” are documented in the DC Municipal Regulations (DCMR) Title 29, Chapter 42, and specify that an individual meet one of the following requirements:

1. Master’s degree and one year of experience with the population, with either a degree in Social work, Psychology, Counseling, Rehabilitation, Nursing, Gerontology, or Sociology;
2. Bachelor’s degree and the above current licensure and 2 years of experience with the population; or
3. A Registered Nurse can [RN] can have an Associate Degree and 3 years of experience, and current license.

**Certificate** *(specify):*

**Other Standard** *(specify):*

Social Service Agency and Community-Based Organization: By-laws or similar documents regulating conduct of providers’ internal affairs; policies and procedure and QA Plan

Minimum standards

1. Each case manager must be an employee of a social service agency and/or other community-based organization hereafter known as the provider, enrolled as a Medicaid provider. Each case manager must perform case management duties either on a full-time basis (i.e., an employee working 0.75 FTE or greater) or on a part-time basis (i.e., an employee working from 0.5 to 0.74 FTE).
2. Each case manager must display accessibility (e.g., to individuals receiving EPD services; to District staff or designees; and to case management agencies, etc.) by acknowledging and responding to inquiries within 24 hours of receipt.
3. Each case manager must self-attest to meeting the CMS conflict-free standards in accordance with 42 CFR § 441.301 (c)(1)(vi), using the DHCF Conflict-Free Case Management Self-Attestation Form.
4. Each case manager will be assigned to no more than 45 individuals, depending on acuity of the persons receiving services, proficiency of the case manager, and level of support (e.g., from a case management assistant, etc.).
5. A case manager must not be an employee of a Home Health Agency or other EPD-waiver direct service provider.
6. Each case manager must demonstrate a service history and current capacity to assist persons in accessing services provided through the District government and/or through community services.
7. Each case management agency must demonstrate a comprehensive knowledge and understanding of the District of Columbia Medicaid program including knowledge of relevant community resources, limitation on State Plan services, and an understanding of the relationship between State Plan and waiver services where applicable.
8. Each case management agency must establish and implement a process by which the person has been informed of his/her freedom of choice rights, and that the person and/or the person’s legal guardian has signed a “Waiver Beneficiary Freedom of Choice Form” indicating that he/she has elected to receive a home and community-based services. Services not provided in accordance with this standard will not be reimbursed
9. Each case management service provider must provide the person and/or the person’s representative, family members and/or legal guardians with agency procedures for protecting confidentiality, for reviewing progress against the PCP, participant rights, and other matters germane to the individual’s decision to accept services.
10. Each case manager is responsible for conducting a comprehensive intake assessment of the person within forty-eight (48) hours of receiving the waiver request and prior to the development of the PCP. The intake assessment findings and PCP must be completed within seven (7) working days of conducting the assessment.
11. Each case manager must include other contributors chosen and invited by the person, and representatives of the person’s interdisciplinary team, as possible, to participate in the initial assessment and the development and implementation of the approved person-centered Individual Service Plan, as per participant request and/or as appropriate.
12. Development of the PCP must include the person whose plan is being developed, other contributors chosen and invited by the person, and representatives of the person’s interdisciplinary team, as possible.
13. It is the responsibility of the case manager to ensure the PCP is provided to the State Agency (or its designee) for approval of services recommended in the PCP. The State Agency (or its designee) will approve or disapprove the services recommended in the PCP within seven (7) working days of its receipt.
14. Each case manager must complete and provide to each case management agency for whom he or she works the DHCF Conflict-Free Case management Self-Attestation form.
15. Each case manager must ensure the person is given the choice to participate in PDS program and/or offered the free choice of all qualified Medicaid providers of each service included in his/her written person-centered Individual Service Plan.
16. Each case manager must provide the person, the person’s representative, family members and/or legal guardians with information on how other needed services (e.g., Medicare, SSI, transit, housing, legal assistance, energy assistance, etc.) may be obtained.
17. All case managers must demonstrate comprehensive knowledge of and actual experience with assisting persons to access all types of community-based programs including legal services, rent assistance programs, food and nutrition programs (including Supplemental Nutrition Assistance Program/SNAP), cash benefit programs (including SSI) and energy assistance programs.
18. As part of on-going monitoring of the person’s person-centered Individual Service Plan, each case manager is required to make an in-home visit to the person at a minimum of at least once per month and more frequently as required by the person’s needs. Supplemental telephone contacts may be made as required by the individual needs of the person receiving services.
19. Case managers must provide services in accordance with provider guidelines and any amendments developed by the State Agency.
20. Each case manager is required to assist the person in accessing all necessary services noted in the person-centered Individual Service Plan, whether they are Medicaid (State Plan) services, Medicaid (Waiver) services and/or non-Medicaid financed services.
21. Each case manager is required to take training by the State Agency (as scheduled and required by the State Agency) in order to promote the efficient and effective delivery of Medicaid-financed services.
22. Each case manager must develop and implement a plan to ensure against duplication of services being provided to the person.

EPD Waiver Case managers shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF prior to providing case management services.

**Verification of Provider Qualifications Entity Responsible for Verification:**

DHCF’s Long Term Care Administration will conduct an initial provider screening and readiness review to ensure programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services. District of Columbia, Department of Health, Health Regulation, and Licensing Administration is also responsible for verification of license.

**Frequency of Verification:**

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years). DHCF will conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enro1ling applicants) located outside of the thirty (30) mile radius of DHCF’s location.DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enro1ling applicants) to verify provider readiness.

**14) Community Transition Services**

**Service Type- Other**

|  |
| --- |
| **Check this box:** |
| **( ) Service is included in the approved waiver. There is no change in service specifications**  **( ) Service is included in approved waiver. The service specifications have been modified.**  **( x ) Service is not included in the approved waiver.** |

**Service Title- Community Transition Services**

**Service Definition**

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institution or other long term care facility to a more integrated and less restrictive community setting. Allowable expenses are those necessary to enable an individual to establish a basic household that does not constitute room and board and may include: (a) application fees and security deposits in the amount of the first month’s rent or greater that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure needed resources.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the transition planning process, and clearly identified in the beneficiary’s transition plan or PCP once they are enrolled in the EPD Waiver.

DHCF or its designee, and Case Managers shall coordinate community transitional supports while a person is an inpatient in an institution or long term care facility. Once the beneficiary transitions to the community and enrolls in the EPD Waiver Program, Case Managers shall coordinate transitional community supports for a period not to exceed six months from discharge into the community. A Financial Management Services Support Broker will be responsible for procuring services and goods on behalf of the beneficiary.

**Specify applicable limits on the amount, duration, and scope of services**

Community Transition Services up to an amount of five thousand ($5,000) may be used as determined in the transition plan development, from the time a tentative discharge date has been established, and someone has been found eligible for the EPD Waiver for a period not to exceed one hundred and twenty days (120) before discharge and up to six (6) months after discharge from an institution or long term care facility.

Community Transition Services do not include monthly rental or mortgage expenses; food beyond pantry set-up; regular utility charges; and/or household appliances or items that are intended purely for recreational purposes; environmental accessibility adaptations services that are of direct medical or remedial benefit to the person, or any durable medical equipment when these services and equipment are covered by a service other than Community Transition Services.

**Provider Category: Agency**



**Provider Type:** Case Management Agency

**Provider Qualifications**

**License***(specify):*

### Any relevant license referenced under the Case Management Service Description in Appendix C

**Certificate** *(specify):***N/A**

**Other Standard** *(specify):*Any relevant standards referenced under the Case Management Service Description in Appendix C

### Verification of Provider Qualifications

**Entity Responsible for Verification:**

DHCF’s Long Term Care Administration will conduct an initial provider screening and readiness review to ensure EPD Waiver programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services. District of Columbia, Department of Health, Health Regulation, and Licensing Administration is also responsible for verification of license.

**Frequency of Verification:**

DHCF’s Long Term Care Administration will monitor programmatic requirements at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years).

DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enro1ling applicants) to verify provider readiness.

**Appendix C-2**

**General Service Specifications (3 of 3)**

**f. Open Enrollment of Providers**

The following processes are used to assure that all willing and qualified providers have the opportunity to enroll as Waiver providers. All qualified Waiver providers are accepted as providers of care. All criteria for Waiver providers are printed and available to any and all interested providers. This information is available online at www.dc-medicaid.com, as well as with the DHCF Office of Provider Services. \*\*There are no time frames for providers to apply to become EPD providers. Once a provider application is submitted for approval, applicants have 30 days to return any requested information. If the information is not returned in 30 days, the application is returned to the provider and the applicant is welcome to reapply at any time in the future.

The provider enrollment process is open to all willing and qualified providers. Each provider has the opportunity to enroll if they meet the approved qualified criteria (State/local and Federal criteria, e.g. District licensure requirements and requisite Code of Federal regulations for the provision of services) for provision of services for the EPD Waiver.

Under the Amendment, Providers have ready access to information regarding requirement and procedures to qualify. This can easily be done by connecting to the Internet and typing www-dc.Medicaid.com. This site maintains all appropriate EPD Waiver providers for enrollment including contact persons.

The Readiness Process begins with a letter from the prospective provider to the EPD Waiver Branch expressing an interest in becoming an EPD Waiver provider. The letter must include:

• Name of the agency with proof of current incorporation in the District of Columbia;

• Contact person with a postal mailing address, business email address and telephone number;

• Brief description of the type of services they would like to provide; and a

• Brief statement of the agency’s readiness to provide the service(s) for which approval is requested. The statement must provide evidence of knowledge and understanding of the relationship between State Plan and Waiver service as related to the service provision(s) for which the applicant is seeking approval.

Prospective providers are expected to forward a Letter of Interest as described above to the following address: LTCAprovider@dc.gov .

Within seven (7) business days of the receipt of a letter of interest from a prospective provider, the LTCA will respond to prospective providers via email and assign a tracking number for future reference. The DHCF’s LTCA will also provide an overview of the readiness process including a contact person for technical assistance, a checklist of required information and a schedule for attending a mandatory orientation session for prospective providers.

The prospective provider is required to attend an information session coordinated by the LTCA. The meeting will include an overview of the Department of Health Care Finance’s mission statement and commitment to federal assurances and performance goals related to the administration and operations of a Home and Community-Based Waiver Service Program. The prospective provider should arrange for availability of key individuals involved with the program/service under review to attend this session.

DHCF anticipates processing applications for participating in the Home and Community Based Medicaid Waiver Services Program within thirty (30) business days of receipt of a complete application packet (Medicaid Application/ Agreement and Program Policies and Procedures). Incomplete applications submitted to DHCF will be returned within fifteen (15) days of receipt. The application should include but not limited to the following: A description of ownership and a list of major owners ,a list of Board members and their affiliations, a roster of key personnel, their qualifications and a copy of their positions descriptions ,copies of licenses and certifications for all staff providing medical services ,the address of all sites at which services will be provided to Medicaid participant ,copy of the most recent audited financial statement of the organization ,a completed copy of the basic organizational documents of the provider, including any organizational chart and current articles of the incorporation , copy of the by-laws or similar documents regulating conduct of the provider’s internal affairs, copy of the business license ,a copy of Joint Commission certification and the submission of any other documentation deemed necessary by DHCF for the approval process as a Medicaid-enrolled provider; additional requirements are Quality Improvement Plan, admission process, Code of Conduct, policies and procedures, and agency complaint process.

Provider applications are submitted to the Fiscal Intermediary, who in turn scans the application and submits the document to the Division of Public and Private Provider Services.

Provider Services reviews the application in accordance with Federal and District screening requirements. Requirements include verification of the submission of the disclosure of ownership form, NPI/Taxonomy Code, liability insurance, surety bond (applicable to those providers rendering PCA services), and checking the Federal exclusion databases.

The application is then sent to the DHCF Division of Long Term Care (DLTC) for review.

The application review will include several components depending on the type of service and the number of services being requested. However, minimally the EPD Waiver Branch will review the following:

• Organizational Policies and Procedures Review

• Financial/Business Plan Review

• Health Care Coordination Plan

• Service and Support Planning

Each component must be satisfied before the prospective provider can be considered qualified. If the applicant fails to successfully satisfy any of the components, the application will be returned and the applicant may reapply following attendance of another Prospective Provider Information Session which will be held quarterly. Each resubmission requires attendance at a Prospective Provider Information Session.

When the EPD Waiver Branch receives the Medicaid Waiver application and the required supplemental materials, the documentation is reviewed by provider readiness review committee (PRC). The Provider Review Committee is a committee composed of representatives from LTCA Staff. LTCA staff may include or consult with the Division of Quality & Health Outcomes, the Division of Public and Private Provider Services and the Healthcare Policy & Research Administration when needed. The Provider Review Committee is charged with the responsibility to review each “new” application and actively participate in the screening and selection or denial process.

An assigned Committee chair is responsible for coordinating and scheduling all activities related to reviewing, discussing, meeting and reporting final determinations from the committee The LTCA staff complete the EPD Provider Qualification Checklist to begin the review. The assigned LTCA staff persons will review reports, if applicable, from other District, federal and or state agencies and evaluate results/outcomes.

Each committee member is expected to read and evaluate each application prior to the meeting. Specifically, each committee member will:

• Review each provider application and supplemental material in its entirety;

• Complete the review and tasks in accordance with the established deadlines;

• Submit comments on the application at least five business days before the scheduled meeting; and

• Attend the entire duration of the committee meeting.

During review meetings, each team member will drill down to validate that the prospective provider satisfies the requirements described in established criteria. Additionally, complete the Readiness review, listing strengths, weaknesses and actionable items for staff assigned if further review is needed. The provider readiness review includes an on-site visit, which should be coordinated with staff from Division of Public and Private Provider services. The team will complete a readiness review that includes a face-to-face interview/meeting with key prospective provider personnel.

The results of the Provider Review Committee are documented in a report prepared by the chair. The final report with comments and recommendations are sent to the EPD Project Manager. The recommendations to approve or to deny an application are routed for agency review and approval process from LTCA Director thru Operations Director to the Medicaid Director, who in turn consults with the Office of General Counsel.

If the application is rejected because of insufficient information the provider is given thirty days to submit the appropriate information. When requested information is not submitted to DHCF within the specified timeframe, the application is returned to the provider as it is assumed he/she is no longer interested in providing services for the District of Columbia. He/she however, is given the opportunity to submit another application at their leisure.

If the application is approved, LTCA will send it over to Division of Public and Private Services. Provider must respond to a request for criminal background checks/fingerprints for all of the names listed on the disclosure of ownership form. They have 30 days from the date of the letter to respond. If no response, then the application is denied. If they respond timely and are no deficiencies, then they will be notified of a request to attend Mandatory Provider orientation conducted by the fiscal agent for programmatic and billing services.

The orientations consist of all policies and procedures of the EPD waiver program, review of requisite rules, program integrity overview, and billing. Once the provider attends the provider orientation, then DHCF will sign the provider agreement and the fiscal agent will assign a DC Medicaid provider number an issue a Welcome Letter to the provider.